MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9218

CERTIFICATE OF DEATH

093268

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Golt
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md. b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Golt
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Ernest — Middle: — Last: Allen

4. **DATE OF DEATH**: Month: August — Day: 1, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 25 1891

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Masonary

11. BIRTHPLACE (County & State, or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY? U.S.A,

13. FATHER'S NAME: Lum Allen

14. MOTHER'S MAIDEN NAME: Nancy Rutter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 221-05-2149

17. INFORMANT: Elizabeth Allen — Address: Golt Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis — 3-4 yrs
DUE TO (c): degeneration of the heart muscle — 3-4 yrs

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept 6, 1960 to Jul. 31, 1961 that (I) (we) last saw the deceased alive on July 4 1961, and that death occured at 11 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Geza Koralewski M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug 2. 61

22c. PHYSICIAN'S NAME (Type): GEZA KORALEWSKI

22d. ADDRESS: MILLINGTON MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 4, 1961

23c. NAME OF CEMETERY OR CREMATORY: Dales Cemetery

23d. LOCATION (City, town or county) (State): Middletown Del.

24 FUNERAL DIRECTOR'S SIGNATURE: Edward Pellow Millington Md. — ADDRESS

25a. REC'D BY REGISTRAR DATE: AUG 7 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9219 **CERTIFICATE OF DEATH** 03209

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Golt
c. LENGTH OF STAY IN 1b: 3yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Golt
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: S. — Last: Beatty

4. DATE OF DEATH: Month: Aug. — Day: 22, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Feb. 17, 1870

9. AGE (In years last birthday): 91 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (County & State, or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George D. Beatty

14. MOTHER'S MAIDEN NAME: No record Yarnall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): ---

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: George D. Beatty Golt Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion

420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arterial Sclerosis

DUE TO (c): Chronic myocardial

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): W

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year: 19 W

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(His Hospital)~~ attended the deceased from Aug 1, 1961 to Aug 22, 1961 that (I) ~~(we)~~ last saw the deceased alive on Aug 15 1961 and that death occured at 4PM from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/23/61

22c. PHYSICIAN'S NAME (Type): C H METCALFE

22d. ADDRESS: [signature] Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 26, 1961

23c. NAME OF CEMETERY OR CREMATORY: Baptist Lower Maerion Cemetery

23d. LOCATION (City, town or county) (State): Bryn Mawr Pa.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Edward Pellow Millington Md

25a. REC'D BY REGISTRAR DATE: AUG 25 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9220

CERTIFICATE OF DEATH

09210

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington. Rural - Home
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington. Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: John — Middle: U. — Last: Chance

4. DATE OF DEATH: Month: August, — Day: 28, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: March, 17, 1874

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Retired.

10b. KIND OF BUSINESS OR INDUSTRY: Farming.

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel M. Chance

14. MOTHER'S MAIDEN NAME: Mary Chance

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.: None.

17. INFORMANT: Dudley Chance, Rural Millington, Md.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO (b): Cerebral arteriosclerosis — years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 61, 19..., to 28 Aug, 19 61, that (I) (we) last saw the deceased alive on 28 Aug 19 61., and that death occured at 2p M, from the causes and on the date stated above.

22a. SIGNATURE: Wallace Obenshain M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 29 Aug 61

22c. PHYSICIAN'S NAME (Type): Wallace Garner Obenshain, M.D.

22d. ADDRESS: Cecilton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 31, 1961

23c. NAME OF CEMETERY OR CREMATORY: Church Hill Cemetery

23d. LOCATION (City, town or county) (State): Church Hill, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows, Millington Md.
ADDRESS:

25a. REC'D BY REGISTRAR DATE: AUG 31 '61

25b. REGISTRAR'S SIGNATURE: Carlton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9221 Reg. Dist. No. 0321

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RFD Chestertown
c. LENGTH OF STAY IN 1b: short
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Chesapeake Bay near Tolchester Beach

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 6220 Brook Ave 3V01-4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle Michael Last Cyran
4. DATE OF DEATH: Month Aug. Day 13, Year 1961
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/6/1933
9. AGE (In years last birthday): 28 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Vending Machine Co.
10b. KIND OF BUSINESS OR INDUSTRY: Employee
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Stanley J. Cyran
14. MOTHER'S MAIDEN NAME: Annabelle (Last Name Not known)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212305849
17. INFORMANT: Mrs Carol Marie Cyran Address: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probably Drowning — INTERVAL BETWEEN ONSET AND DEATH: Short
DUE TO (b): Boating accident in Chesapeake Bay near
DUE TO (c): Tolchester Beach (RFD Chestertown, Md.)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): boat sank
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Chesapeake Bay
20f. (City or town) Kent Co. (County) Maryland (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Robert W. Farr M.D.
EXAMINER'S NAME (Type): Robert W. Farr
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/16/61

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 8-18-61
22c. NAME OF CEMETERY OR CREMATORY: Baltimore National
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Leonard J. Ruck 5305 Harford Rd.
24a. REC'D BY REGISTRAR DATE: AUG 18 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Norris

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9222

CERTIFICATE OF DEATH

Items 3 & 16 Film G294 9/13/61 iwk

09212

1 (M)

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 107 High Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dee ~~Dover~~ — Middle: ~~Leroy~~ — Last: LeRoy Doub

4. DATE OF DEATH: Month: 8 — Day: 4 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 6/12/84

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor Steam plant-Penna. Railroad

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: David Doub

14. MOTHER'S MAIDEN NAME: Alice Kenny

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: don't know — 716-07-7071

17. INFORMANT — Address: Dover L. Doub (previous adm.) Chestertown, Md.

I

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day

420.1

DUE TO (b): Arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c): Chronic pulmonary congestion

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic renal insufficiency

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 8-3, 1961, to 8-4, 1961, that (I) ~~(was)~~ last saw the deceased alive on 8-4-1961 and that death occured at 9 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Harry Paul Ross M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-5-61

22c. PHYSICIAN'S NAME (Type): HARRY PAUL ROSS

22d. ADDRESS: 203 N. Queen Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/8/61

23c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery

23d. LOCATION (City, town or county) (State): Chestertown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE AUG 8 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

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Item 1 Film G294 9/7/61 iwk

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9223

Reg. Dist. No. 10213

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETTERTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hotel Rigby

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 805 St. Paul Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First DAVID Middle Last FINCH

4. DATE OF DEATH: Month AUGUST Day 15 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 13, 1887
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Madison Apts.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Rowland Finch
14. MOTHER'S MAIDEN NAME: Georgella Ramey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-34-3377
INFORMANT: A Mrs. Eleanor K. Finch Address: 812 Beaumont Ave. 12

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 5 min.
+33.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic auricular fibrillation — ?
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute pyelonephritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 14, 1961, to August 15 1961 that I last saw the deceased alive on August 14, 1961, and that death occurred at 2 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Florence Deringer Joyce MD
ADDRESS (Street, city or town, state): MD
DATE SIGNED: 8-15-61

PHYSICIAN'S NAME (Type): FLORENCE DERINGER JOYCE WORTON, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/17/61
22c. NAME OF CEMETERY OR CREMATORY: Greenmount Ave.
22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm J Tichnor & Son
ADDRESS: North & Ross ave Balto 17 Md.
24a. REC'D BY REGISTRAR DATE: AUG 17 '61
24b. REGISTRAR'S SIGNATURE: Arthur J. Russ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9224

CERTIFICATE OF DEATH

9214

1. PLACE OF DEATH
a. COUNTY: Kent, Chestertown, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: four days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent and Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Queen Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown, R. D.
d. STREET ADDRESS: 1 X
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF (Type or print): First: Walter Middle: H. Last: Hadaway, Jr.

4. DATE OF DEATH: Month: August Day: 5 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: December 17, 1891

9. AGE (In years last birthday): 69 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Walter H. Hadaway, Sr.

14. MOTHER'S MAIDEN NAME: Virginia Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO: 220-34-9204

17. INFORMANT Address: Hospital Records - Chestertown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Tetanus
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 10 Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/1/41, to 8/5/61, that (I) (we) last saw the deceased alive on 8/5/61, and that death occured at 8.48 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Thomas Solon M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 8/6/61

22c. PHYSICIAN'S NAME (Type): THOMAS SOLON
22d. ADDRESS: Chestertown Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8/8/61
23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel
23d. LOCATION (City, town or county): Rock Hall (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: Edgar L. Lane Church Hill Md

25a. REC'D BY REGISTRAR DATE: AUG 10 '61
25b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9225 **CERTIFICATE OF DEATH** 09215

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall (rural)
d. STREET ADDRESS: RFD#1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nettie — Middle: Frances — Last: Mercer

4. DATE OF DEATH: Month: 8 — Day: 1 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/1/93

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Poole

14. MOTHER'S MAIDEN NAME: Barbara Zellers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 213 14 1221

17. INFORMANT — Address: Mrs. Catherine Williams, Rock Hall, Md. (daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary arteriosclerosis & Congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/27 ..... 19 61 to 8/1 ..... 19 61 that (I) (we) last saw the deceased alive on 8/1/61 ..... 19 .., and that death occured 10 .. M, from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Farr M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug 1 1961

22c. PHYSICIAN'S NAME (Type): Robert W. Farr

22d. ADDRESS: Chestertown Md.

23a. (BURIAL) CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 3-61

23c. NAME OF CEMETERY OR CREMATORY: Worsley Chapel

23d. LOCATION (City, town or county): Rock Hall Md (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Evelyn L. Lane — ADDRESS: Church Hill

25a REC'D BY REGISTRAR DATE: AUG 7 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Ward

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9225 — 95216 — Reg. Dist. No.

1. PLACE OF DEATH — a. COUNTY: Kent — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Maryland — b. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall — c. LENGTH OF STAY IN 1b: Short — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Electric Sub Station (Rock Hall) — d. STREET ADDRESS: 207 Queen St. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ XXX

3. NAME OF DECEASED (Type or print): First: C. Allie — Middle: — Last: Myers
4. DATE OF DEATH: Month: Aug. — Day: 3, — Year: 1961
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 19, 1902
9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician Mainteance
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Kent CO. Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Edwin Myers
14. MOTHER'S MAIDEN NAME: Mary Emma Brice
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): none — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 096-09-9220
17. INFORMANT: Mrs. Elise Myers — Address: Queen St. Chestertown Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ELECTROCUTION — INTERVAL BETWEEN ONSET AND DEATH: NONE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (b): — DUE TO (c):
914.3
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Accidentally touched 2400 volt line in Electric Substation
20c. TIME OF INJURY: 11 Boo a. m. p. m. — Month, Day, Year: AUG 3 1961
20d. INJURY OCCURRED: While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Sub-station
20f. (City or town) ROCK HALL (County) KENT (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: O. S. Gulbrandsen M.D. — CHIEF MEDICAL EXAMINER ☐ — DATE SIGNED
EXAMINER'S NAME (Type): O. S. GULBRANDSEN, M.D. — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ Acting — 8/3/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/5/61
22c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery
22d. LOCATION (City, town, or county) (State): Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR — DATE: AUG 7 '61
24b. REGISTRAR'S SIGNATURE: A. Ann L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9227

CERTIFICATE OF DEATH

Reg. Dist. No. 11921

1 PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First AGNES — Middle — Last ROUSE
4. DATE OF DEATH: Month AUG. — Day 6 — Year 1961

5. SEX: Fem.
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: JUNE 3 - 1881
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): IOWA
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: RUBEN ROUSE
14. MOTHER'S MAIDEN NAME: ROSANNA GOODEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MRS. F.R. KENT = Address ROCK HALL MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cardio Vascular — unknown
DUE TO (c): Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 25, 1961, to Aug 6, 1961, that I last saw the deceased alive on Aug 5, 1961, and that death occurred at 5 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Norbert C. Tisch M.D. ADDRESS (Street, city or town, state): Rock Hall Md. DATE SIGNED:
PHYSICIAN'S NAME (Type): NORBERT C. TISCH ROCK HALL MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: AUG. 9
22c. NAME OF CEMETERY OR CREMATORY: ST. JOHNS
22d. LOCATION (City, town, or county): ROCK HALL (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane ADDRESS: Church Hill, Md.
24a. REC'D BY REGISTRAR DATE: AUG 10 '61
24b. REGISTRAR'S SIGNATURE: Miles S. Knox

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9228

CERTIFICATE OF DEATH

09218

M

I

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown (rural)
d. STREET ADDRESS: RFD#2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thelma — Middle: Catherine — Last: Shinnamon

4. DATE OF DEATH: Month: 8 — Day: 14 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/29/03
9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel J. Boyd
14. MOTHER'S MAIDEN NAME: Sara H. Scully

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Thelma C. Shinnamon — Address: (Hospital records)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism, postoperative — INTERVAL BETWEEN ONSET AND DEATH: 45 minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-30, 1961 to 8-14, 1961 that (I) (we) last saw the deceased alive on 8-14-61 19.. ....., and that death occured at 5:25 a.m. from the causes and on the date stated above.

22a. SIGNATURE: A C Dick M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-14-61
22c. PHYSICIAN'S NAME (Type): A.C. Dick
22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): B
23b. DATE THEREOF: 8-17-61
23c. NAME OF CEMETERY OR CREMATORY: Elkridge
23d. LOCATION (City, town or county) (State): Elkridge, Md

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: McCully - 130 E Fox Lane

25a. REC'D BY REGISTRAR DATE: [illegible] 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Knowe

VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9229 — 0921

CERTIFICATE OF DEATH

Item 9 Filed 6292 6/21/61 lwk

1. PLACE OF DEATH
a. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN MARYLAND: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rock Hall
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Pownall; Last: Tierney

4. DATE OF DEATH: Month: 8; Day: 26; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/9/07

9. AGE (In years last birthd): 53/54 — IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Vincent Pownall

14. MOTHER'S MAIDEN NAME: Bertha Walton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give wars or dates of service):

16. SOCIAL SECURITY NO: don't know

17. INFORMANT: James J. Tierney — Address: Rock Hall, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 410X — Nutritional and probable electrolyte disturbance due to vomiting and refusal to eat — Interval between onset and death: Several Weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Congestive failure — 6 months

DUE TO (c): Mitral stenosis and insufficiency — Many Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/23/61, 19, to 9/26/61, 19..., that (I) (we) last saw the deceased alive on 8/26/61, 19, and that death occured 10:25 AM from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Farr, M.D.

ATTENDING PHYS. X MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/27/61

22c. PHYSICIAN'S NAME (Type): Robert W. Farr

22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 8/28/61

23c. NAME OF CEMETERY OR CREMATORY: Silverbrook Crematory

23d. LOCATION (City, town or county) (State): Wilmington, / Dela.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells

ADDRESS: Chestertown Md. Chestertown, Md.

25a. RECD BY REGISTRAR DATE: JUN 29 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9230

CERTIFICATE OF DEATH

03220

Item 2 Film G293 8/18/61 mb -ITEM "13 - SEE BIRTH CERTIFICATE

1. PLACE OF DEATH
a. COUNTY KENT MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN
c. LENGTH OF STAY IN 1b LIFETIME
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENT + QUEEN ANNE'S HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CHESTERTOWN RFD #4 JMA Still Pond
d. STREET ADDRESS KENT + QUEEN ANNE'S HOSPITAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First HARRY Middle LEWIS Last WALLEY
4. DATE OF DEATH Month AUGUST Day 13 Year 1961
5. SEX MALE
6. COLOR OR RACE NEGRO
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH AUG 13, 1961
9. AGE (In years last birthday) ——yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours 2 Min. 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (County & State, or foreign country) KENT - MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S BORN
13. FATHER'S NAME LEWIS ~~WALLEY~~ Wilson
14. MOTHER'S MAIDEN NAME MARY WALLEY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) NO —
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Address HOSPITAL RECORDS CHESTERTOWN, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FETAL ATALECTASIS — INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
762.5 DUE TO (b) PREMATURITY (22 wks 1 lb 3 oz)
DUE TO (c) —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 —
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from AUG 13, 1961 to AUG 13, 1961, that (I) (we) last saw the deceased alive on AUG 13 1961, and that death occured at 6:15 PM, from the causes and on the date stated above.

22a. SIGNATURE O.S. Gulbrandsen M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 8-13-61
22c. PHYSICIAN'S NAME (Type) O.S. GULBRANDSEN, M.D.
22d. ADDRESS CHESTERTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 8-14-61
23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMTY
23d. LOCATION (City, town or county) STILL POND, (State) MD.

24 FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy
ADDRESS STILL POND, MD.
25a. REC'D BY REGISTRAR DATE AUG 15 '61
25b. REGISTRAR'S SIGNATURE Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9231

CERTIFICATE OF DEATH

09221

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: 1½ days

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: MD. b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN 37
d. STREET ADDRESS: 212 COURT ST. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KENT & QUEEN ANNE'S GEN.

3. NAME OF DECEASED (Type or print): First DONNA Middle LYNN Last WILSON

4. DATE OF DEATH: Month AUG. Day 21 Year 1961

5. SEX: Fe. 6. COLOR OR RACE: N 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH: AUG. 19, 1961 9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months 0 Days 1 IF UNDER 24 HRS. Hours 34 Min. 42

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? AM.

13. FATHER'S NAME: JESSIE - WILSON JR.
14. MOTHER'S MAIDEN NAME: NORMA JEAN BLACK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Foetal Atelectasis — INTERVAL BETWEEN ONSET AND DEATH
762.5
DUE TO (b): PREMATURITY
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH [IF EITHER, NOTIFY MEDICAL EXAMINER]
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-19-61 to 1961 to 8-21- 6 AM 19 61, that (I) (we) last saw the deceased alive on ..... 19 ..... and that death occured at 6 AM, from the causes and on the date stated above.

22a. SIGNATURE: Harry Paul Ross M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): HARRY PAUL ROSS
22d. ADDRESS: 203 N. Queen ST Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/22/61
23c. NAME OF CEMETERY OR CREMATORY: MORGNEC CEM.
23d. LOCATION (City, town or county) (State): near Chestertown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Kenneth Wadey
ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR DATE AUG 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruns

2072 141 X'6